

## THE ORERE SOURCE

Abstracts from the Pastoral Care literature and other Helping Professions

### Protocols for Chaplains?

Several weeks ago, I received an e-mail request from a graduate student in psychology at a well-respected church-related college. She had been asked to prepare a course that would be used to teach undergraduates how to provide pastoral care to persons in hospital. It is a college, many of whose graduates do in fact end up as ministers, or in other kinds of pastoral work. She was asking that I send her samples of "protocols that are used to teach chaplains about how to minister in different, commonly-encountered pastoral situations e.g. when a person is dying, when a person is addicted, when a person is not complying with their medication regimen, when a person is grieving". How would you have responded?

Most chaplains in the US don't think in terms of protocols. We are more at home explaining either in general religious terms, or in slightly more behavioral though nonspecific ways that what we do is active listening - meeting the patient where they are at and where the patient sets the agenda. Or we explain what we do in terms of narrative theology, where, again, we engage in active listening but couple that with processes of meaning-making. We are aware of the grieving process, and we can explain the why's and wherefores of our ritual practices. But protocols?

Last week I had lunch with one of the psychologists in the hospital and she was talking about some of the new activities of the Wellness Institute where she is on the staff. She described some of the advances in health-promoting behaviors that she and her colleagues are now being expected to promote and which are offered to patients: anxiety-reduction before surgery, stress reduction after surgery, "self-efficacy training" (watch out for that phrase in the future!) for all kinds of patients - HIV, cardiac recovery, pain control, addictive behaviors, anxiety-reduction for the terminally ill. As she spoke, I began to say to myself: "These are many of the areas that my chaplain colleagues and I are concerned about, not all areas, but many. They are problems as

well as areas of life that patients talk to us about all the time. Why are psychologists now being asked to do what we already do? Don't they know that we do many of these things already. Or is it that we don't do them very well, and someone has decided that what we often do can be done more effectively by someone else? Will we and the psychologists engage in some kind of turf-skirmishing, or will we all be so busy that we never get to that point with persons who are religious-inclined seeing a chaplain, and others seeing the psychologist"?

At the end of the week I was reviewing the departmental log from the previous night. It is the record in which the on-call chaplains makes notations describing their activities so that the staff will know the next morning what took place during the night. The chaplain who had been on-call the previous night was new, one of our CPE Interns who prior to attending seminary had been a social worker. He obviously brings the skills he learned in his social work practice to his work in ministry. One of his notes caught my attention. He had been called to visit a very anxious patient, a woman so agitated that the nurse has taken the initiative and called the chaplain unbeknownst to the patient. He had spent about 30 minutes establishing rapport with her and then asked her about what was upsetting her. She had then described to him what it was, whereupon he reported that he had "led her through a creative visualization exercise." He described what he had done, and concluded by noting that when he left, the woman seemed calm and also grateful for his visit. Ten years ago, such an intervention by a chaplain in the US would have been considered quite daring, though less so today. Should a chaplain be able to offer ministry in this way as easily as they offer prayer?

It appears that the question we will have to face is this: will we extend our practices to include interventions in areas of people's lives that we have traditionally been concerned about, but now, using insights from the behavior services which permit the creation of "protocols" which will enable those who have the training to minister using more precise and

skilled interventions? The Intern knew that he had more to offer than the traditional reassurance and scripture and prayer. He used a skill which he knew because he had been trained in its use, though not in seminary.

Consider the matter of forgiveness. Insights from studies of the nature of forgiveness suggest there are ways in which a health care professional can interact with a patient in order to facilitate healing for their troubled spirit. But this necessitates establishing a covenant with the patient, and following a protocol, providing an intervention that some (for example the psychologists) might say - "this activity belongs to

us." Yet, as chaplains we would respond, "Forgiveness has been one of our responsibilities for 2000 years. This is our territory. We are simply going to use the discoveries of your field and become more effective chaplains."

I hear the footsteps of Nathaniel Micklem who many years ago wrote about the relationships between Sacred and Secular in his little volume of the same name. What do you include in your ministry that had its origins in the secular world, and how do you decide what now insights, and practices can rightly be baptized for use in your ministry?

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**Lodovico Balducci, Russell Meyer**  
**Spirituality and medicine: a proposal**  
**Cancer Control**

**Vol. 8 # 4 (Jul/Aug 2001) Pp. 368-376**

This is a summary article, with a proposal. The authors - a physician and a parish minister - take the reader through the recent literature concerning spirituality and health - the problems with defining spirituality, and the question of how to understand the relationship between spirituality and psychology. In the first section a suggestion is made which is new to the medicine/spirituality dialogues. The proposal is "that the concept of sacrifice (be used) in medical investigations as a marker of defined spirituality perspectives."

They then turn to the matter of how to study spirituality. They claim there are four basic issues which need to be studied: 1. the relationship of spirituality and public health. 2. the efficacy of a spiritual perspective in overcoming addictive disorders; 3. the influence of a patient's and practitioner's spirituality on disease outcomes; and, 4. the influence of spirituality on patient-physician communication. They point out that research has already been completed on aspects of these topics and highlight 15 studies already published.

The implications? They highlight the implications in the practice of medicine, on medical education, and on future research.

This article will help the reader understand how the thoroughgoing scientist/doctor will look at the question of spirituality and medicine. Who as chaplain

would put on the research agenda: "Define "gold standard" of spirituality to validate current and new instruments." Or, "Perform dose/effect study of spirituality and health preservation." This is an added reason reading such an article, putting, as it does, the spirituality/health dialogue in new and unexpected ways.

**Jacqueline Barnes, Leanda Kroll, Olive Burke, Joanna Lee, Alison Jones, Alan Stein**  
**Qualitative interview study of communication between parents and children about maternal breast cancer**

**British Medical J**  
**Vol. 321 # 7259 (19 Aug 2000) Pp. 479-482**

What do mothers diagnosed with breast cancer tell their school-aged children about their illness, and when do they do so? The authors arranged for 32 women with stage I or II to be interviewed.

The results show that women are most likely to talk to their children after a biopsy has confirmed the diagnosis, but a minority either waited till after surgery, or said nothing at all. The reasons for saying nothing were fairly consistent. The women wanted to avoid having to answer their children's questions, especially any concerning death. It transpires that few mothers are given any assistance in how to talk with their children about future problems, including the possibility of death, though many would have liked that help.

Is this a potential role for chaplains?

**Christine E. Gudorf**

**The richness of religious healing in Latin America**

**Second Opinion**

**Vol. 7 (Jul 2001) Pp. 27-54**

With a long history of arrivals of people from various foreign cultures, and now widespread poverty over many years, these factors are the main contributors to the creation of a wide diversity of systems of healing across Latin America. What would be considered traditional medicine in Europe or the US is the exception for the majority of the population there today.

Gudorf describes the implications of this situation for people on this continent, as well as some observations pertinent to those of us living in Europe and the US. For example, important ethical issues in the northern hemisphere are generally not discussed in Latin America. And the Human Genome Project has triggered heated ethical discussions because the indigenous people of six countries have objected to having their genetic material stolen and patented by the Project.

It is a wide-ranging paper, full of fascinating vignettes. For example, take the Anointing of the Sick as practised in the Roman Catholic Church. "Unable to shake the moniker of "last rites," this sacrament has not been successfully recast as a sacrament of healing. Families frequently either fail to ask for it or even refuse to have their sick anointed until illness is clearly terminal, out of fear that the sacrament will signal to the patient and others that death is inevitable.

Gudorf finishes her essay with some lessons that we might learn from Latin America. For instance: "There is mystery, magic and gift in healing. It is perhaps one important spiritual lesson we can learn from Latin America. In a religious sense, North Americans have lost a great deal of our sense of finitude, of dependence on God, of gratitude for the health and healing we receive, as well as compassion for those who have not received health and healing." (p.49)

**Wai-Ching Leung**

**Results of genetic testing: when confidentiality conflicts with a duty to warn relatives**

**British Medical J**

**Vol. 312 # 7274 (9 Dec 2000) Pp. 1464-1466**

If through genetic testing a patient is found to have an inherited disease, the results have implications for the person's entire family. If screening is avail-

able to test for the disease, that test is usually then offered to anyone in the family who might be affected. But what if an identified patient is confirmed as having a disease but insists that their family is not to be told about the diagnosis? That dilemma is at the heart of this case study.

A 23 year-old man is seen by a psychiatrist because of increasing paranoid ideas. He is eventually diagnosed as having Wilson's disease. His two siblings have a 1 in 4 risk of having the disease, which can (and should) be treated before symptoms appear. The man refuses to allow his siblings to be told. What is the appropriate ethical response to this dilemma? Three doctors state their opinions, A challenging case for an ethics seminar, focussing on a type of issue which will become increasingly common in the years ahead as the relationships between genetics and disease are clarified.

**Christopher Martyn**

**Xenotransplantation - website of the week**

**British Medical J**

**Vol. 322 # 7301 (23 Jun 2001) Pp. 1552**

The work that has made organs transplantation fairly routine today has been one of the therapeutic triumphs of the past quarter century. Unfortunately, demand for organs has far outstripped the supply raising ethical dilemmas about the allocation of these scarce resources.

One response has been the development of Xenotransplantation - the use of animal organs in human patients. This article lists four websites where the ethical problems associated with this practice are well presented. There are three UK and one US site. Try

[www.wellcome.ac.uk/en/1/misinfbibxen.html](http://www.wellcome.ac.uk/en/1/misinfbibxen.html) and [www.srtp.org.uk/xennuf03.htm](http://www.srtp.org.uk/xennuf03.htm) for starters.

**David L. Massey**

**Theological and biblical interpretations of current movements and emerging paradigms within bereavement studies**

**Pastoral Psychology**

**Vol. 48 # 6 (Jul 2000) Pp. 469-486**

Models for understanding grief and the grieving process have been changing during the past 10 years. The earlier descriptive models and the stage models, which are based on medical ways of thinking have slowly been giving way to non-hierarchical models that "emerge internally, inherently, and intrinsically from within the bereaved." The pastoral person's role within this understanding of grief is,

according to Massey, to be "a companioning presence."

Having introduced this newer way of understanding the grieving process, Massey considers that process alongside some recent thinking from the fields of theology and biblical theology. It is a rich foray on his part.

This is not a paper of warmed-over ideas that add little to our thinking about grief and suffering. There have been many such in recent years. Here we are asked to consider grief and grieving in different ways, bringing with us a fuller sense of the Scriptures as we do so. Massey also raises questions about a number of other issues. e.g. the implications of disenfranchised grief, and masculine patterns of bereavement, among other issues.

**Andrew Moscrop**

**Empathy: a lost meaning?**

**Western J of Medicine**

**Vol. 175 # 1 (Jul 2001) Pp. 59-60**

Moscrop, a fourth-year medical student at the University of Edinburgh is critical of the ways in which some medical writers and educators "have exploited" the term empathy. He accuses them of encouraging sham responses of apparent empathy in order to aid communication.

Moscrop asserts that empathy involves hard work by the physician to understand the thoughts and emotions of their patients - "it demands a conscious cognitive effort." He points out that such work has benefits for both the patient as well as for the doctor.

**J.J. Paris, A.C. Elias-Jones**

**"Do we murder Mary to save Jodie?" An ethical analysis of the separation of the Manchester twins**

**Postgraduate Medical J**

**Vol. 77 # 9 (Sept 2001) Pp. 593-598**

The authors of this paper, one in the UK, the other in the US take the words of one of the Lord Justices of the Court of Appeal in England who permitted the separation of conjoined twin girls in late 2000. It is a valuable paper

The authors describe the events that led to the twins being brought to the UK from Malta. The parents were Roman Catholics and had brought the girls because of their religious belief that "everyone has a right to life."

It was quickly discovered that if the girls were not separated both would die. If they were separated,

one would die and the other would have "the quality (of life) of that of an ordinary child." Based on this assessment, the parents opted not to proceed with the surgery, "quite happy for God to decide what happened to their two young daughters".

The authors then examine how the Court of Appeal decided to overrule the wishes of the parents. And this is the central issue for this paper. Whose decision can or should it be to overturn the clear wishes of a child's parents. The authors carefully describe the arguments which the Court gave in making their decision. (The authors are not persuaded by the Court's logic.)

On 6 Nov. 2000 the twins were separated. Mary died during the procedure, Jodie survives.

**David Reilly**

**Enhancing human healing - editorial**

**British Medical J**

**Vol. 322 # 7279 (20 Jan 2001) Pp. 120-121**

"All therapeutic avenues meet at life's innate healing or destructive processes." With these words Reilly urges his profession - he is a medical doctor - to take seriously, and include all of the approaches and processes which can contribute to the healing of sick humans. "In recent decades orthodox medicine's successful focus on specific healing interventions has meant relative neglect of self-healing and holism.....The gap between them is, however, narrowing with the emerging view, backed by the study of placebo and psychoneuroimmunology, that to ignore the whole person factors is unscientific and less successful." (p.120)

He further argues that the study of human healing should include "spiritual practices" not as ends in themselves but as "portals to common ground in creative change." (p.121)

The article is yet another voice in mainstream medicine urging the inclusion of non- traditional medicine in mainstream medicine's practice.

**Richard Smith**

**Why are doctors so unhappy? - editorial**

**British Medical J**

**Vol. 322 # 7294 (5 May 2001) Pp. 1073-1074**

An examination of the reasons doctors in the UK are unhappy. Smith thinks that what doctors think about patients, and vice-versa currently forms a "bogus contract." Doctors are often acutely aware of the limitations of what they can do, whereas patients - partly through the exaggeration of doctors - have inflated ideas about the power of medicine."

Smith spells out the elements of a possible new contract, for both doctors and patients. It would include the acknowledgements that:

Death, sickness and pain are part of life.

Medicine has limited powers, particularly to solve social problems, and is risky.

Doctors don't know everything: they need decision-making and psychological support.

We're in this together.

Patients can't leave problems to doctors.

Doctors should be open about their limitations.

Politicians should refrain from extravagant promises and concentrate on reality.

**Alexander M Smith**

**Obtaining consent for examination and treatment - editorial**

**British Medical J**

**Vol. 322 # 7290 (7 Apr 2001) Pp. 810-811**

A professor of medical law describes and comments upon a newly published guide from the Department of Health called "Reference guide to consent for examination or treatment. Smith describes how doctors should go about obtaining consent, and when they can proceed without consent. He also points out that there is still tension concerning the issue of what information needs to be given to a patient as case law is still evolving on this matter.

The document can be downloaded at: [www.doh.gov.uk/consent](http://www.doh.gov.uk/consent)

**Janice L. Wakefield, R. David Cox, Janet S. Forrest**

**Seeds of change: the development of a spiritual assessment model**

**Chaplaincy Today**

**Vol. 15 # 1 (- 1999) Pp. 41-50**

A narrative description of the process of development and introduction of a pastoral care department's psycho-social/spiritual screen, which is used to identify patients needing pastoral care. The screen is now included in the formal assessment of

all hospitalised patients. The questions which have been developed are used by nursing staff during their initial nursing assessment at admission. The screen automatically triggers referrals of patients to pastoral care if a person is identified as needing pastoral care assessment and intervention. The screen itself has been well received, tested and proved reliable and is now used by all nursing staff in the authors' hospital. The entire system has been commented on very favourably by Joint Commission for the Accreditation of Hospitals Organisations' (JCAHO) reviewers.

In addition, in their article, the authors describe how they worked to effect a major process change in their hospital. Copies of the screening instrument are included in the article's appendix.

**Cheryl Westlake, Kathleen Dracup**

**Role of spirituality in adjustment of patients with advanced heart failure**

**Progress in Cardiovascular Nursing**

**Vol. 16 # 3 (- 2001) Pp. 119-125**

The authors describe the role of spirituality in the adjustment processes made by persons suffering from advanced heart failure. Eight-seven persons were interviewed using a semi-structured interview format to gather information about how exactly they were adjusting.

The authors discovered that people appear to follow a three-step process within which spirituality contributes to the adjustments they make. 1. the development of regrets concerning past behaviours and lifestyles. 2. a search for meaning within their current experience of heart failure. 3. a search for hope for the future and a search for ways to rediscover optimism.

In the background section of this paper, there is a good review of earlier literature which has described the role of spirituality in AIDS patients, patients with cancer patients with chronic obstructive pulmonary disease, and terminal illness.